

Policy Agreement and Disclosure Form

I agree that I have read and understand the policies of the office of Bemis Tupman Chiropractic including the privacy policy, the office policy and the financial policy. I understand that I have the right to request a copy of these policies at any time.

This form allows Bemis Tupman Chiropractic to follow requirements by HIPPA (Health Insurance Portability & Accountability Act). HIPPA does not allow a physician office to give medical information to anyone, including family members or friends, unless permission is given in writing by the patient.

I, _____, give permission for the following person/persons to receive medical information regarding my health. I understand this may be changed at any time, but must be done in writing by filling out another form. This form will be part of my permanent medical record.

I hereby allow Bemis Tupman Chiropractic to release my medical information to the following individual(s) :

Name	Relationship	Date
Name	Relationship	Date
Name	Relationship	Date

Please Sign Below:

Name(Printed)	Signature	Date
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If you are a minor, or represented by another party:

Personal Representative (Printed)	Personal Representative (Signature)	Date
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